ADVENTIST HOSPITAL & CLINIC SERVICES (M) v. KEE BOON SUAN & ANOR AND ANOTHER CASE

HIGH COURT MALAYA, GEORGETOWN
NORDIN HASSAN JC
[CIVIL SUITS NO: 22NCVC-85-02-2013 & 22NCVC-307-10-2013]
14 JULY 2015

TORT: *Negligence – Medical negligence – Patient becoming quadriplegic after undergoing spinal surgery – Whether due care and skill exercised in treating patient – Test applicable to determine standard of care – Whether informed consent obtained for surgery – Whether patient properly advised regarding need for surgery – Whether surgery properly carried out – Whether post operative care was proper and sufficient – Whether there was organisational and system failure in hospital – Non-delegable duty of care owed by hospital to patients – Whether hospital vicariously liable for negligence of doctors and nurses – Whether causation established – Whether patient entitled to special and general damages*

The plaintiff in the original action operated and managed Penang Adventist Hospital ('the hospital'). The first and second defendants were the parents of Kee Jun Hui ('the patient'), a 12 year old girl. The patient was admitted to the hospital for spinal surgery. The plaintiff's claim was for the outstanding medical bills. The plaintiff's claim was not disputed by the defendants. In the counterclaim, the defendants and the patient were the plaintiffs and the plaintiff in the original action was the first defendant. The second and fourth defendants in the counterclaim were the consultant orthopaedic and spine surgeons who carried out the operation on the patient at the hospital and the third defendant was the anaesthetist assigned by the hospital for the said operation. The plaintiffs' counterclaim was for damages for medical negligence by the defendants in respect of the care, management and treatment of the patient. The plaintiffs had brought the patient to the hospital for consultation for the patient's spinal deformity. The second defendant had conducted physical examination on the patient and concluded that the patient had Idiopathic Scoliosis. Thereafter, the second defendant informed the father about the surgery that the patient required. The father signed a consent form for the said surgery and the surgery was carried out uneventfully. After the surgery, the patient was placed in the Intensive Care Unit (ICU) and was later removed to the paediatrics general ward. At the general ward, on the same day, the patient became drowsy and there was no response from her. The father called the nurse who came but told the plaintiffs not to worry as it was only due to the pain relief medication given to the patient. The patient later collapsed in the ward and only regained her heartbeat and respiration after active resuscitation. The neurological assessment of the patient showed no movement of the patient's upper and lower limbs. Thereafter, another operation was carried out to remove the implants from the patient but there was no neurogical improvement of the patient's condition. The patient became quadriplegic. She was paralysed from the neck down and was

dependent on a ventilator for breathing. The issues arising for determination were: (i) whether the second, third and fourth defendants had acted with due care and skill in treating the patient; (ii) whether the second and fourth defendants had acted in accordance with the standard of care expected of an orthopaedic and spine surgeon; (iii) whether the third defendant had acted with the standard of care expected of an anaesthetist; (iv) whether the first defendant was negligent and in breach of its contractual duty in the treatment and management of the patient; (v) whether the first defendant was vicariously liable for the negligence of the second, third and fourth defendants; (vi) whether the injuries suffered by the patient were caused or materially contributed by the negligence of the defendants; and (vii) whether the plaintiffs were entitled to special damages and general damages.

Held (allowing claim and counter claim):

(1) The plaintiff had established its claim for the medical charges. The plaintiff's claim for the total medical charges in a sum of RM2,350,013.85 was allowed. (para 15)

(2) It is the duty of the court to determine the standard of care to be observed by doctors or medical practitioners in a medical negligence case by evaluating the evidence presented by parties which includes the opinion and practices of members or body of that profession. (paras 73 & 74)

(3) It is the duty of medical practitioners to inform and explain the material risks of the proposed treatment to patients unless it falls under therapeutic privilege which the non-disclosure is for the best interest of the patient. The second defendant did not advise or explain the risk of quadriplegia to the patient or her parents. The risk of quadriplegia in the surgery was a material risk and ought to be explained to the father for him to make an informed decision. As such, there was a breach of duty of care on the part of the doctors for failing to obtain an informed consent from the father before the said surgery. (paras 82, 83 & 90)

(4) There was nothing on the second defendant's medical records that showed any medical indication for the said surgery. The second defendant decided that the patient required the surgery without having the medical records or clinical information of the patient. There was also no observation made on the progression of the patient's scoliosis. The contemporaneous medical record did not indicate any medical indication for surgery. Therefore, there was no medical indication for the second defendant to advice for the surgery to be carried out. In advising the father to give his consent, the second defendant had breached of his duty of care to the patient. (paras 93, 99 & 100)

(5) The patient was put in the prone position during the surgery and subjected to hypertensive anaesthesia which had led to quadriplegia and without having the spinal cord monitoring facilities. This was a breach

of duty of care on the part of the doctor. Further, the facilities at the hospital at the material time was inadequate and this affected the performance of the doctors. This was a breach of duty of care to the patient by the hospital and also an organisational and system failure. (paras 113, 115 & 116)

(6) The second defendant was negligent and in breach of duty of care when he gave the instruction to transfer the patient out of the ICU prematurely and without consulting the anaesthetist. He was also negligent for failing to give specific instruction to the nurses even though the patient needed close observation and monitoring after the said surgery. The failure to inform the doctors after having received the complaint that the patient became drowsy was a negligent act of the nurses, taking into account the unstable condition of the patient. The non-observation and monitoring of the patient at least half hourly was also another negligent conduct by the nurses and the doctors. (paras 132-134)

(7) The plaintiffs had proven causation on the balance of probabilities. It was proven that the surgery performed by the doctors had caused the patient to suffer quadriplegia. (paras 136 & 138)

(8) The hospital medical administration had not set the required safety protocols or policies. The nurses at the hospital were not well trained apart from the facilities which were inadequate. The patient care had suffered due to the problems between the doctors and the hospital management. The organisational and system failure of the hospital gave rise to direct liability on the part of the hospital. (paras 142 & 143)

(9) A hospital owes a non-delegable duty of care to patients and to ensure that the healthcare provided either by its servant or agent under a contract of service or contract for service is not negligent. This doctrine of non-delegable duty is an extension of the concept of direct liability of a hospital. There was no reason not to apply this doctrine in the present case. (paras 147-150)

(10) The nurses of the hospital were negligent and in breach of duty of care to the patient. As the nurses were employees and staff of the first defendant, the first defendant was vicariously liable for their negligent act. The hospital also had some control over the doctors in the performance of their duty in the hospital. The doctors were in fact the agent of the hospital in providing the healthcare to the patient. Therefore, the hospital was also vicariously liable for the negligent acts of the doctors. (paras 153 & 157)

Case(s) referred to:

Bennett v. Minister of Community Welfare [1992] 176 CLR 408 ***(refd)***
Bonnington Castings Ltd v. Wardlaw [1956] AC 613 ***(refd)***
Cassidy v. Ministry of Health [1951] 2 KB 343 ***(refd)***
Dr Ismail Abdullah v. Poh Hui Lin [2009] 7 CLJ 167 HC ***(refd)***
Eddy anak Entering v. Azimudin bin Majidin & Anor [2014] 1 PIR [16] ***(refd)***

Foo Fio Na v. Dr Soo Fook Mun & Anor [2007] 1 CLJ 229 FC ***(refd)***
Gleneagles Hospital (KL) Sdn Bhd v. Chung Chu Yin & Ors and Another Appeal [2013] 8 CLJ 449 CA ***(refd)***
Ku Jia Shiuen & Anor v. Kerajaan Malaysia & Ors [2013] 9 CLJ 489 HC ***(refd)***
Majuikan Sdn Bhd v. Barclays Bank PLC [2014] 9 CLJ 337 CA ***(refd)***
McGhee v. National Coal Board [1973] 1 WLR 1 ***(refd)***
Nurul Husna Muhamad Hafiz & Anor v. Kerajaan Malaysia & Ors [2015] 1 CLJ 825 HC ***(refd)***
Ong Ah Long v. Dr S Underwood [1983] 2 CLJ 198; [1983] CLJ (Rep) 300 FC ***(refd)***
Roe v. Minister of Health [1954] 2 QB 66 ***(refd)***
Rogers v. Whitaker [1992] 175 CLR 479 ***(refd)***
Schrump Et Al v. Koot Et Al Lexsee 18 OR (2D) 337 ***(refd)***
Shanmugam Gopal v. Zinal Abidin Nazim & Anor [2003] 8 CLJ 729 HC ***(refd)***
Yang Salbiah & Anor v. Jamil Harun [1981] 1 LNS 106 FC ***(refd)***

Legislation referred to:
Evidence Act 1950, s. 103

Other source(s) referred to:
A Jones, *Medical Negligence*, 2013 edn

For the plaintiff - Mahinder Singh Dulku (Fazleeza Azli & Nga Mei Yan with him); M/s Chan Ban Eng & Co
For the defendant - MS Dhillon (Rhina Bhar & KB Karthi with him); M/s Rhina Bhar & Assocs
For the 2nd & 4th defendants - J Yeoh (Siti Hawa Ahmad Aani with him); M/s Shearn Delamore & Co

Reported by Amutha Suppayah

JUDGMENT

Nordin Hassan JC:

Introduction

[1] There are two suits before this court related to the same subject matter which are Civil Suit No. 22NCVC-85-02/2013 and NCVC-307-10/2013. In these two suits, the plaintiff's claim is for the outstanding medical expenses in respect of the care, management and treatment of the defendants' daughter Kee Jun Hui at Penang Adventist Hospital.

[2] In Civil Suit No. 22NCVC-85-02/2013, the claim is for the outstanding medical charges for the period of 31 July 2011 to 31 January 2012 in the sum of RM218,606.10 and in the Civil Suit No. 22NCVC-307-10/2013, for the unpaid medical bills for the period of 31 January 2012 to 28 February 2013 for the amount of RM537,477. The plaintiff then amended the statement of claim in Civil Suit No. 22NCVC-307-10/2013 to include the claim for the outstanding medical bills from 29 February 2013 to 30 September 2014 for the amount of RM873,553.65.

[3] The defendants thereafter filed their defence and counterclaim against the plaintiff in these two suits for damages for medical negligence on the part of the doctors and Penang Adventist Hospital.

[4] On the 8 September 2014, this court ordered the two suits to be consolidated and heard together.

[5] The plaintiff in the original action is a company incorporated under the Companies Act 1965 who operates and manages Penang Adventist Hospital.

[6] The first and second defendant are the parents of Kee Jun Hui and reside at No. 717, Jalan 5, Kg. Veldor, Sg. Bakap, Sg. Jawi, Penang.

[7] The second and fourth defendants in the counterclaim are consultant orthopaedic surgeons who carried out the operation on the patient at the hospital and the third defendant is the anaesthetist assigned by the hospital for the said operation.

Briefs Facts

(The original action in relation to the outstanding medical bills).

[8] On 2 June 2008, Kee Jun Hui ("the patient") was admitted to the Penang Adventist Hospital ("the hospital") for spinal surgery which was scheduled on the 3 June 2008.

[9] As the patient's parents, the first and second defendants had financial difficulties to bear the costs for the surgery, the hospital, under the Dr Earl Gardner Fund agreed to contribute RM55,000 towards the cost of the surgery which was about RM70,000. Subsequently, the hospital agreed to grant a 30% coverage of the medical bills under the Sabbath Fund for a period of one year which was until 26 May 2009.

[10] In any event, the hospital did not impose any charges against the defendants until after the expiry of the period given in its letter to the defendants dated 23 December 2010 informing that the patient was medically fit to be discharged from the hospital.

[11] Except for the deposit of RM20,000, the medical bills for the period of 31 July 2011 to 31 January 2012 for the amount of RM218.606.10, the period of 31 January 2012 to 26 February 2013 for the amount of RM537,477 and the period of 29 February 2013 to 30 September 2014 in the sum of RM873,553.65 were not paid by the defendants. As the medical charges is continuing on a daily basis, the total amount claimed by the plaintiff from the period of 31 July 2011 to 31 March 2015 is RM1,900,013.85.

Plaintiff's Contention

[12] The plaintiff submitted that the outstanding medical charges to be paid by the defendants were supported by the medical bills found in bundle 'G', bundle "I" and document "annexure A".

Defendant's Position

[13] The plaintiff's claim for the said outstanding medical bills is not disputed and the defendants' counsel agree that the said claim is to be allowed as mentioned in his oral submission and as stated at para. 177 of the defendants' written submission.

A **Decision Of The Court**

[14] It is trite law that the party who alleges a fact must produce evidence in proof of it as clearly stated under s. 103 of the Evidence Act 1950.

[15] In the present case, the plaintiff had established its claim for the B medical charges by tendering all the medical bills through the plaintiff's witness, Lim Fong Cheng (PW1), the Senior Manager of Customer Affairs, Relation and Experience of the hospital.

[16] PW1 testified that the unpaid medical charges for the period 31 July 2011 to 31 January 2012 is RM218,606.10 and from 31 January 2012 to C 28 February 2013 is RM537,477. She then identified all the medical bills in bundle "G" as the bills for the said period.

[17] PW1 in her evidence also confirmed that the outstanding medical charges to be paid by the defendants for the period from 29 February 2013 to 30 September 2014 is RM873,553.65 by referring to the medical bills at D pp. 30 to 114 of "bundle I". Therefore, the total outstanding medical bills from 31 July 2011 to 30 September 2014 is RM1,629,636.75.

[18] Apart from that, the medical bills incurred from 30 September 2014 to 31 March 2015 in the sum of RM270,377.10 was shown by referring to the documents in "annexure A". Therefore the total outstanding medical E charges which has been proven from 31 July 2011 to 31 March 2015 is RM1,900,013.85.

[19] However, with regard to the medical charges after 31 March 2015, no medical bills were presented in this court and the testimony of PW1 only F stated that the average cost for the care and management of the patient is about RM50,000 to RM60,000 per month. No evidence was adduced for the daily cost incurred by the hospital or specific amount incurred monthly. In any event, as it is not disputed that the hospital incurred cost for the care and management of the patient, the reasonable cost is RM50,000 monthly. The month of January 2012, where the medical bills was RM49,803.54 is one of G the basis for me to decide the amount of RM50,000 as the average monthly medical charges for the patient. Therefore, on the reasonable assumption that the patient will be discharged six months from the date of judgment, the amount of medical charges after 31 March 2015 will be nine months x RM50,000 which is RM450,000. As such I allow the plaintiff's claim for the H total medical charges in a sum of RM1,900,013.85 + RM450,000 = RM2,350,013.85.

Defendants' Counterclaim

[20] In the counterclaim, the defendants and Kee Jun Hui are the plaintiffs I and the plaintiff in the original action is the first defendant with Dr Cheok Chee Yew as the second defendant, Dr Patrick Tan Kee Seng as third defendant and Dr Wong Chung Chek as the fourth defendant.

[21] The plaintiffs' claim is for damages for medical negligence by the defendants in respect of the care, management and treatment of Kee Jun Hui, the third plaintiff at Penang Adventist Hospital .

[22] The second and fourth defendants are consultant orthopaedic and spine surgeons whilst the third defendant is the consultant anaesthetist.

Brief Facts

[23] On 2 May 2008, the first plaintiff brought his 12 years old daughter, the third plaintiff ("the patient") to Penang Adventist Hospital ("the hospital") for consultation for the patient's spinal deformity. At the hospital, the patient was attended by Dr Cheok Chee Yew, the second defendant.

[24] The second defendant then conducted physical examination on the patient and found the presence of a higher left shoulder with a stiff right thoracic hump and a plump line 2cm off centre. There was no neurological deficit. The x-ray of the patient revealed that the patient had a double thoracic curve with cobb's angle: T1 - T5 = 62 degrees and T6 - T12 = 100 degrees. The second defendant then concludes that the patient had Idiopathic Scoliosis.

[25] Thereafter, the second defendant informed the first plaintiff about the surgery that the patient requires and due to the high costs for the surgery, the second defendant suggested the surgery to be done at Penang General Hospital. Earlier, prior to the meeting with second defendant, the patient was brought by first plaintiff to Penang General Hospital for consultation for the patient's spinal deformity.

[26] However, the first plaintiff preferred the surgery to be done at the hospital. The second defendant then recommended the first plaintiff to seek financial assistance from the welfare body of the hospital. Upon application made, the hospital agreed to contribute RM55,000 for the cost of the surgery under Dr J Earl Gardner Fund and subsequently agreed to grant a 30% coverage of the medical bills for a period of one year under the Sabbath Fund.

[27] On 2 June 2008, the patient was admitted into the hospital with the operation scheduled on the 3 June 2008. The second defendant then obtained the approval from the hospital for the fourth defendant to assist him to perform the surgery.

[28] On the same day, 2 June 2008, the first plaintiff signed a consent form for the said surgery.

[29] The third defendant is the anaesthetist who was assigned by the hospital to perform the anaesthetic for the patient in respect of the said spinal surgery which was scheduled on the 3 June 2008.

[30] On 3 June 2008, the surgery was carried out by the second and fourth defendants with the third defendant as the anaesthetist. The surgery took about seven hours from 9am to 4pm.

[31] The surgery was performed with the patient in the prone position and hypertensive anaesthesia was administered with a view to reduce the bleeding. The surgery was uneventful.

[32] After the surgery, whilst the patient was still in the Intensive Care Unit (ICU), the second defendant instructed the patient to move her legs which the patient was able to do.

[33] On the 4 June 2008 at 11.15am the second defendant noted in the Nursing Report 'T/O to Paed's ward' which indicates the instruction to transfer the patient out of the ICU to the paediatrics general ward. This was confirmed by the second defendant in his evidence. The patient was then transferred to the general ward.

[34] At the general ward, on the same day, when the patient was awake, the first and second plaintiffs spoke to her. The patient then became drowsy and the second plaintiff tried to wake her up but there was no response from her. The first plaintiff then called the nurse who came but told the plaintiffs not to worry as it was only due to the pain relief medication given to the patient and said that the patient needed a lot of rest. The nurse then left the room.

[35] On the same day, at about 2.50pm the ward nurse informed the second defendant that the patient had collapsed in the ward and when the second defendant arrived at the ward, he was informed by the staff nurse that the ward nurses had carried out active resuscitation by way of cardiac massage, ambu-bagging and cardio-pulmonary resuscitation (CPR) and that the patient had regained her heartbeat and respiration.

[36] The patient was then transferred back to the ICU for further observation and was put on a ventilator.

[37] On 5 June 2008, the neurological assessment of the patient showed no movement of the patient's upper and lower limbs. The second defendant then discussed with Dr Khaw Poh Guan, the consultant paediatrician and Dr Samuel Easaw, the consultant neurologist at the hospital and two other spinal surgeons. It was the consensus of the doctors that the implants be removed from the patient to exclude any possible cause of the neurological deficit.

[38] Thereafter the first plaintiff was informed by the second defendant the decision and the rationale to remove the implants and a written consent was obtained from the first plaintiff. On the same day 5 June 2008 at 4pm, the second defendant removed all the implants from the patient.

[39] After the implants were removed, there was no neurological improvement of the patient's condition.

[40] The x-rays and MRIs done after the removal of the implants showed as follows:

(i) MRI of the brain on 11 June 2008 showed 'diffuse acute infarction of the spinal cord/medulla with hemorrhagic transformation';

(ii) MRI of the cervical spine on 11 June 2008 showed 'extensive acute infarction of lower medulla and cervical spinal cord with hemorrhagic transformation in the central cord'; and

(iii) MRI of the thoracic spine on 17 June 2008 showed 'extensive cord oedema and infarction'.

[41] The patient was quadriplegic. She was paralysed from the neck down and was dependent on a ventilator for breathing.

Issues To Be Tried

[42] The issues to be tried in this case are as follows:

(i) whether the second, third and fourth defendants had acted with due care and skill in treating the patient, the third plaintiff;

(ii) whether the second and fourth defendants had acted in accordance with the standard of care expected of an orthopaedic and spine surgeon;

(iii) whether the third defendant had acted with the standard of care expected of an anaesthetist;

(iv) whether the first defendant was negligent and in breach of its contractual duty in the treatment and management of the patient;

(v) whether the first defendant is vicariously liable for the negligence of the second, third and fourth defendants;

(vi) whether the injuries suffered by the patient were caused or materially contributed by the negligence of the defendants; or

(vii) whether the plaintiffs are entitled to special damages, general damages, interest and cost as pleaded.

The Plaintiffs' Contentions

[43] Basically, the plaintiffs contended that the negligence of the defendants occurred at three stages which were:

(i) the pre-operation;

(ii) during operation; and

(iii) the post operation.

[44] At the pre-operation stage, the plaintiffs submitted that the doctors had failed to obtain an informed consent from the parents and failed to advice the parents and the patient the material risk of quadriplegia.

[45] It was also submitted that there was no medical indication for the operation to be carried out and the said operation was only a cosmetic procedure. Counsel then contended that the parents were influenced and persuaded by the second defendant that the patient needed the operation.

[46] Counsel for the plaintiffs also contended that the doctors had failed to observe the progression of the patient's scoliosis over a period of time before giving advice for the patient to undergo the operation. Furthermore, it was argued that the doctors had failed to obtain any medical report or clinical information from Penang General Hospital knowing that the patient had earlier been referred to Penang General Hospital.

[47] During the operation, the plaintiffs submitted that as the patient was put in a prone position and subjected to hypertensive anaesthesia which can cause vascular problems, the spinal cord monitoring (SCM) should have been used continuously during the operation. However, in this case no spinal cord monitoring was used during the said operation.

[48] With regard to the post operation, the plaintiffs contended that the premature transfer of the patient out from the ICU to the general ward and failure to undertake close observation of the patient had led to the patient's collapse and consequence quadriplegia. The plaintiff also submitted that the second defendant had failed to consult the anaesthetist, the third defendant before giving the instruction to transfer the patient to the general ward. The second defendant was also said to have failed to give any instruction to the nurses for the care and management of the patient.

[49] The plaintiffs further submitted that the nurses of the hospital were negligent in failing to inform the doctors about the complaint that the patient being drowsy in the ward.

[50] The plaintiffs also argued that the hospital was directly liable for the hospital's organisational and system failure. It was submitted that there was lack of proper safety protocols, inadequate facilities and insufficient numbers of experienced and trained nurses at the hospital.

[51] Counsel for the plaintiffs also contended that the hospital owed the patient a non-delegable duty of care as the hospital itself is a provider of healthcare.

[52] On the issue of vicarious liability, it was submitted that the first defendant is vicariously liable for the negligence of its staffs which are the nurses. As for the second, third and fourth defendants, it was argued that the doctors are the hospital's agents in providing the healthcare to the patient and as such the first defendant is vicariously liable for their negligent.

[53] The plaintiffs then submitted that the negligence of the defendants had caused the patient to suffer quadriplegia.

[54] The plaintiffs further contended that the patient is entitled to the damages and costs as pleaded based on *inter alia*, the testimony of Dr Balwant Singh Bains (PW5) and Dr Mohd lzmi bin Ahmad (PW6).

The First Defendant's Contentions

[55] Firstly, the first defendant submitted that the plaintiffs' pleading only pleaded causation against the three doctors and not against the hospital. As such, the plaintiffs are bound by the pleading.

[56] Secondly, it was contended that the doctors are not agents or employees of the hospital. They have entered into a contract for services with the hospital and therefore the issue of vicarious liability does not arise.

[57] The first defendant then submitted that the plaintiffs are not entitled to claim for general damages against the hospital in respect of pain and suffering in relation to the quadriplegia as it was not pleaded and the plaintiffs have not adduced medical evidence to establish that the patient's quadriplegia was caused by the hospital.

[58] As regards the special damages, the first defendant contended that the plaintiffs' claims have not been proven and disputed the claims made by the plaintiffs.

The Contentions Of The Second, Third and Fourth Defendants

[59] Firstly, counsel for the second, third and fourth defendants contended that the care and management of the patient on the part of the doctors preoperatively, intra-operatively and post-operatively had not caused or contributed to the patient's quadriplegia.

[60] It was also submitted that informed consent of the father had been obtained and the common foreseeable risks and complications of the scoliosis surgery had been explained to the father. The father had been informed about the risk of paraplegia, infection, bleeding and non-union.

[61] Counsel also submitted that the indication for surgical interventions to correct the thoracic scoliosis is very clear as the S shaped curve was larger than 45 degrees. It was further argued that the thoracic curve at near 100 degrees in this case if left uncorrected would affect the patient's lung and cardiac functions.

[62] Counsel for second, third and fourth defendants also contended that the patient had to be placed in a prone position during surgery as the corrective surgery for double cures is only possible through a posterior approach to the spine. Furthermore it was argued that all precautionary measures had been taken to prevent direct pressure on the patient's eyes, abdomen, elbows, knees and ankles.

[63] It was also submitted that the use of hypertensive anaesthesia is a common practice in spinal surgery to reduce bleeding and the patient's quadriplegia was not caused or relates to the hypertensive anaesthesia administered during the surgery. Furthermore, it was submitted that the patient was able to move her limbs and breaths on her own after the surgery.

[64] Apart from this, counsel for the doctors contended that the doctors' post operative care and management of the patient is not within the plaintiffs' pleaded case against the doctors and therefore the plaintiffs' case should be dismissed.

[65] It was further argued that even if the negligence of the doctors post operatively is within the plaintiffs' pleaded case, it was submitted that there had not been any want of care and management on the part of the doctors.

[66] Counsel for the doctors also submitted that the premature transfer of the patient from ICU to the paediatric ward does not reflect any want of care on the part of the second defendant and did not cause the patient's respiratory arrest or quadriplegia.

[67] Counsel for the doctors then contended the premature transfer, the respiratory arrest and events leading to the patient's quadriplegia are matters within the hospital's system of post operative health care for which the hospital is not only directly responsible for organisations failure but accountable for its non-delegable duty of care.

[68] It was further submitted that the hospital is vicariously liable for the act and omissions on the part of the doctors irrespective of whether they are independent contractor. Counsel then argued that the provisions in the agreement entered between the doctors, the hospital and the consultant company further confirmed that both the second and third defendants are not independent contractors but are employees of the hospital.

[69] In respect of the special damages, it was submitted that the damages should not be assessed on the basis of homecare but on the basis of institutional care in a hospital or medical centre.

[70] As to the general damages, it was contended that the amount of RM350,000 is a reasonable amount taking into account the award for a patient who was not only quadriplegia but mentally retarded in the case of *Ku Jia Shiuen & Anor v. Kerajaan Malaysia & Ors* [2013] 9 CLJ 489; [2013] 4 MLJ 108.

Findings Of The Court

[71] It is settled law that a doctor owes a duty of care to his patient. This duty arises out of the relationship with the patient when the doctor provides advice, diagnosis or treatment to the patient.

[72] The often-quoted Federal Court case on this issue of duty of care is *Foo Fio Na v. Dr Soo Fook Mun & Anor* [2007] 1 CLJ 229, [2007] 1 MLJ 539 where it stated:

> That duty of care has been aptly described by Lord Hewart CJ in *R Bateman* (4925) 94 LBKB 79 to be as follows:
>
> > If a person hold himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No, contractual relation is necessary nor is it necessary that the service be rendered for reward.

[73] It is also clear that the Federal Court in *Foo Fio Na*'s case accepted the test in *Rogers v. Whitaker* [1992] 175 CLR 479 and elaborated the principle of duty of care as follows:

> Therefore, there is a need for members of the medical profession to stand up to the wrong doings, if any, as is the case of professionals in other professions. In so doing people involved in medical negligence cases would be able to obtain better professional advice and that the courts would be appraised with evidence that would assist them in their deliberations. On this basis, we are of the view that the *Rogers v Whitaker* test would be a more appropriate and viable test of this millennium then the Bolam test. To borrow a quote from Lord Woolfe's inaugural lecture in the new Provost Series, delivered in London in 2001 the phrase "Doctor knows best should now be followed by the qualifying words 'if he acts reasonable and logically and get his facts right".

[74] Thus, it is the duty of the court to determine the standard of care to be observed by doctors or medical practitioners in a medical negligence case by evaluating the evidence presented by parties which includes the opinion and practices of members or body of that profession.

[75] After having mentioned the principle of standard of care, the next question for determination is whether there was any breach of duty of this standard of care by the defendants.

[76] In the present case, I will address the relevant issues raised by parties especially at the three stages as contended by the plaintiffs where the negligence of the defendants were said to had occurred. The stages as mentioned earlier are the pre-operation, during operation and the post operation.

The Pre Operation

[77] Firstly is the issue of informed consent. The rationale of this doctrine of informed consent is to give the patient sufficient information about the proposed medical treatment so as to unable the patient or the parents to make

an informed decision as to whether to proceed with the treatment or otherwise. This certainly involved the explanation as to the risks of the proposed treatment.

[78] This issue of informed consent has been explained by Siti Norma Yaakob FCJ in *Foo Fio Na*'s case as follows:

> That said, we are of the opinion *Bolam* Test has no relevance to the duty and standard of care of medical practitioner in providing advice to patient on the inherent and material risks of the proposed treatment. The practitioner is bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment.

[79] Having read the statement of law by Siti Norma FCJ in *Foo Fio Na*'s case, I am of the view that the words "the risks" mentioned by the judge refers to the risks mentioned at the beginning of the statement which are 'inherent and material risks'.

[80] In any event, as the Federal Court in *Foo Fio Na*'s case applied the principles established in *Rogers v. Whitaker* (*supra*), it is clear that only material risks of injury arising out of the treatment need to be disclosed to the patient.

[81] On the same issue, the principles in *Rogers v. Whitaker* which was quoted in the case of *Dr Ismail Abdullah v. Poh Hui Lin* [2009] 7 CLJ 167; [2009] 2 MLJ 599 are relevant in this case. At para. 20, p. 608 it says:

> Some very important principles are established in *Rogers v. Whitaker*. A few of them, in so far as they are relevant to the present case, are:
>
> (i) only material risks of injury arising out of treatment or surgery need to be disclosed to a patient;
>
> (ii) the materiality or non-materiality of a risk often requires expert evidence; and
>
> (iii) the therapeutic privilege allows a surgeon to withhold disclosure a material risk in the best interest of a patient.

[82] Therefore, it is the duty of medical practitioners to inform and explain the material risks of the proposed treatment to patients unless it falls under therapeutic privilege which the non-disclosure is for the best interest of the patient.

[83] In the present case, the first plaintiff who signed the consent form was not called to testify on this issue. Be that as it may, it is not disputed that the second defendant did not advise or explain the risk of quadriplegia to the patient or her parents as clearly noted on the consent form. It only stated the risk of paraplegia.

[84] In relation to this issue, the plaintiffs called an expert Dr Kuldip Singh (PW2) who *inter alia* testified as to the risk of quadriplegia in a spinal cord surgery. In his testimony he said this:

> If you look at TWIA, Q23, he had obtained consent from the father, explained to the risk of surgery which included paraplegia,
>
> ... The other is Quadriparesis, that means you become paralysed from the neck downwards. Although it is rare, but it is important for the father to know before he make an informed decision whether to go for surgery. It's not here

[85] The risks of quadriplegia is not something new in the spinal cord surgery as mentioned in the literatures cited by PW2 in bundle 'M' which among others are:

(i) 'Anaesthesia In The Prone Position'; and

(ii) 'Quadriplegia After Lumbar Disc Surgery'.

[86] As one of the principles established in *Roger v. Whitaker* (*supra*) is that the materiality or non-materiality of a risk requires expert evidence, therefore the evidence of Dr Kuldip (PW2) is of significance to assist this court on this issue. In this case, PW2 testified that the risk of quadriplegia in the surgery is material risk and ought to be explained to the father for him to make an informed decision.

[87] In his expert report dated 19 June 2012, PW2 said this:

> The cause of the quadriplegia is due to a cervical cord and medulla infarct. This complication is not idiopathic or of unknown cause. Although rare, this has been reported in literature.

PW2 also was not cross-examined by counsel for the defendants and his evidence to my mind is not obviously indefensible.

[88] In *Majuikan Sdn Bhd v. Barclays Bank PLC* [2014] 9 CLJ 337 the Court of Appeal stated this:

> We are in agreement with these principles and in our view, a judge who is not an expert himself, should defer to expert opinion unless that evidence is obviously indefensible and is not supported by the basic facts of the case. Where there are conflicting expert opinion, the judge is of course entitled to bring to bear his own judicial appreciation of the matter, and choose one over the other, but where there is only one expert opinion, he should not as a rule reject that opinion outright without judiciously considering whether it is obviously indefensible and unsupported by the basic facts of the case. Such a principle is in accord with the principle that the court is the final obiter, as stated on *Dr. Shanmuganathan v. Periasamy Sithambaram Pillai* [1997] 2 CLJ 153; [1997] 3 MLJ 61;

> ... the principal object of expert evidence is to assist the court to form its own opinion. An expert, should give his reasons. The court is the final arbiter, not the experts or witnesses ... The learned Judge should have considered the reasoning given by the expert and with that assistance arrive at the conclusion. In failing to do so the learned Judge had abdicated his function. The learned Judge is entitled to reject the evidence but not before considering such evidence ...

[89] Therefore, having considered the evidence, the opinion of PW2 and having read the literatures before this court, I am of the view that the risk of quadriplegia in spinal cord surgery as in this case is a material risk which the second defendant had failed to explain to the father. The facts also shows that third and fourth defendants did not explain the risks to the father before they were involved in the said surgery for whatever tasks assigned to them.

[90] As such there was a breach of duty of care on the part of the doctors for failing to obtain an informed consent from the father, the first plaintiff before the said surgery.

[91] The next issue in respect of the pre-operation stage is the doctor's failure to observe the progression of the patient's scoliosis before giving advice to the father for the patient to undergo the surgery. It was also the plaintiffs' contention that the surgery is only a cosmetic procedure and there was no medical indication to perform the surgery.

[92] On this issue, the second defendant, having met the patient for the first time on the 2 May 2008 noted in his record as shown at p. 2 of bundle 'B' as follows:

> Idiopathic Scoliosis
>
> - noted deformity 1 year ago.
> - no symptom - able to participate in school activity.
> - normal development mile-stone.
> - Follow up in Penang GH for scoliosis.
> - Advised for surgery.
> - Awaiting for financial assistance.

[93] There is nothing on the second defendant medical records, the contemporaneous document, that shows any medical indication for the said surgery. As mentioned earlier, the second defendant in his testimony however said that there was clear medical indication for the surgery and if uncorrected would affect the patient's lung and cardiac function. However, this view was made without having the medical records or clinical information of the patient from the Penang General Hospital.

[94] On the other hand, the expert, Dr Kuldip (PW2) was of a different view on this issue. In his testimony, PW2 had this to say after being referred to the medical report prepared by the second defendant on 10 February 2000.

Q: Dr. Dhillon, may I refer you to Bundle D, page 19.

"Indication of surgery: Rapid progression of cure over one year. Deformity Double Thoracic curve - cobbs angle: T1-T5 = 60°; T6 - T12 = 100°. And your recommendation is 40 to 45 is usually recommended.

Would you agree, Dr. Dhillon, that these indications warrants surgical indication?

A: No. I already mentioned, its no. This patient's plumb line is only 2 cm here. As I said, in the same page, if you see under 'History of Patient illness plumb line 2 cm off centre, that means very slight tilts. It is not even a cosmetic problem, what's the need to correct the deformity.

Q: 60 to 100 degrees , it all over your range, Dr. Dhillon?

A: No, this is double curve ...

Q: It may be double curve but it is beyond your range, your range of recommendation is.

A: It is not my range, never said that.

Q: 40 to 45, which is your recommended range?

A: It is not my recommended range.

[95] PW2 further explained the reasons why in the present case he would not recommend for surgery as stated at p. 123 of the notes of proceeding as follows:

A lot of doctors will recommend surgery after the curve exceed 40, 45 degrees because they realised, they follow these patient for several years, the curve increased about 1 degree per year, on average. So you need to follow up these patient over several years, you see how rapid the progression is. Some, if progress 1 degree, by the time she is 17, she stop growing, the curve won't progress. So you calculate, by the time she stop growing, how much the curve would be. If the curve, is going to 100°, single curve, she is going to walking like this, it won't be very good.

If the patient has got double curve, even if it progresses, it won't be a major cosmetic problem. So I won't even recommend surgery.

[96] When asked further about the condition of the patient with her curve degrees T1 - T5 at 60°,T6 - T12 at 100° and how much longer the doctors have to wait before any surgical, Dr Kuldip explained as follows:

I believe that you must follow-up and see whether there is an indication. I say the main indication is cosmetic. In this patient, there is minimal cosmetic deformity because it is a double curve. So you don't even need to do any surgery. It is single curve, you are 45 degrees, she got 5 more years to grow, it may become 100° you may want to consider because it becomes a cosmetic problem.

[97] Again PW2 was not cross-examined on this issue to challenge his opinion. The doctors only submitted the supplementary witness statements to put their stand on the issue. PW2 had no opportunity to respond to the doctors' contentions which among others with regard to the contention that the delay in carrying out the surgery would affect the patient's lung and cardiac function.

[98] The second defendant also in his evidence admitted that it is important to observe the patient over a period of time to see the progression of the scoliosis.

[99] In the present case, as there was no observation made on the progression of the patient's scoliosis, no medical records or information of the patient obtained from Penang General Hospital, the contemporaneous medical record on 2 May 2008 does not indicate any medical indication for surgery and the evidence of Dr Kuldip on this issue was not strictly challenged, I am of the considered view that the expert opinion of Dr Kuldip (PW2) is reasonable and acceptable.

[100] Therefore, it is my findings that there was no medical indication for the second defendant to advice for the surgery to be carried out. In advising the first plaintiff to give his consent in this case clearly in breach of his duty of care to the patient.

The Operation

[101] As regards the issue that the patient was put in the prone position and subjected to hypertensive anaesthesia during surgery, this court had considered all relevant evidence including the evidence of the experts.

[102] The doctors were of the view that the prone position and the administering of hypertensive anaesthesia are a common practice in spinal surgery and they have taken all the necessary precaution to ensure the patient's safety.

[103] On the other hand, Dr Kuldip (PW2) in his testimony explained in detail the risk of positioning the patient in a prone position and the administration of hypertensive anaesthesia which could lead to quadriparesis.

[104] PW2's opinion is supported with the literatures presented in court especially, the article 'Anaesthesia In The Prone Position' by H Egcombe, K Carter and S Yarrow. In this art. at pp. 169 and 170 under the heading 'complications associated with the prone position' the authors explain how the spinal surgery with the prone position could lead to quadriplegia.

[105] The evidence of PW2 was supported by another expert Dr Sylvian Dass and they are of the view the need to have the spinal cord monitoring (SCM) during the operation to monitor the cord continuously as surgery with the prone position could lead to quadriplegia.

[106] As explained by PW2 the cause of quadriparesis is not due to cord distraction at the time of the correction of the deformity but due to ischemic of the cord due to a vascular event. Therefore the spinal cord monitoring may show early signs of ischemia of the cord.

[107] PW2 then stated that doctors should not be doing scoliosis surgery without having the spinal cord monitoring facilities.

[108] Professor Dr Chan Yoo Kuen, (DW3) an expert called by the defendants also acknowledged the importance of the spinal cord monitoring facilities in spinal surgery.

[109] In her evidence, she said this:

> Q: In a major operation like this, where the patient is put in a prone position and subjected to hypertensive anaesthesia, how can the spinal cord monitoring equipment assist the clinician?
>
> A: In this particular surgery, what they are actually trying to do is to straighten out the spine that has gone, in layman's term crooked. So they would like to straighten it. But in straightening it, they can actually stretch the bones and ultimately the cord. So the function of the cord is to allow the nerves transmission from the lower limbs back to the brain and also for transmission of further impulse from the brain downwards. So, when the surgeons operate and they distract the cord that means they have actually stretched too far, the function of the cord will be compromised. So this monitoring is to actually help us determine whether there has been a compromise at all in this cord. And if there is a compromise then the surgeon should use this monitor to tell him to reduce the distraction, that means, instead of pulling that long, to reduce the distraction so that the injury would not be there or would be minimal.

[110] The spinal cord monitoring facilities is not new to the medical world as it was introduced as early as in the 1970's as confirmed by Professor Chan. Her working place at University Malaya Medical Centre also has the spinal cord monitoring facilities.

[111] As all the experts, including the expert called by the doctors confirmed the importance of having a spinal cord monitoring facilities in a spinal surgery, I have no reason to have a different view. I am satisfied that the opinion of the experts is capable of withstanding any logical analysis.

[112] I am also of the view that the wake-up test which was carried out once in the said surgery is not an efficient method to monitor the cord continuously during the surgery.

[113] In the present instance, as the patient was put in the prone position during the surgery and subjected to hypertensive anaesthesia which had led to quadriplegia and without having the spinal cord monitoring facilities, to my mind it is a breach of duty of care on the part of the doctors.

[114] On top of that, on the part of the hospital as stated in its 'mission' which is to provide a comprehensive, competent and excellent healthcare has failed to provide the spinal cord monitoring facilities which is important in a spinal surgery and in the present case had led the patient to suffer quadriplegia.

[115] Dr Patrick Tan, the third defendant himself in his evidence had testified that the facilities at the material time were inadequate and this affects the performance of the doctors.

[116] As such, I am of the view that this is a breach of duty of care to the patient by the hospital and also an organisational and system failure.

The Post Operation

[117] Firstly, is the issue of the patient being transferred from the ICU to the normal ward, the patient was transferred upon instruction given by the second defendant. She was transferred out from the ICU on the 4 June 2008 about 17 hours after the surgery. The second defendant had made the decision to transfer the patient without informing Dr Patrick Tan, the anaesthetist. The second defendant also did not give any instruction to the ward nurses with regards to the patient's care and management.

[118] The facts also shows that at the time when she was transferred out from the ICU, the pulse rate was not normalised and the blood pressure and the urine output was low. The patient's condition was then still unstable.

[119] Professor Dr Chan (DW3), the expert called by the doctors, confirmed the fact that the patient was then in unstable condition and of the view that she needs closer monitoring of her blood pressure, heart rate or cardiovascular system. Professor Chan then agreed that the decision to transfer the patient from the ICU to the general ward was premature.

[120] DW3 also agreed that Dr Patrick, the anaesthetist, is the qualified person to manage the patient in the ICU and considering the condition of the patient, DW2 said that the second defendant should have consulted Dr Patrick before making the decision to transfer the patient out from the ICU to the general ward.

[121] In addition to this, DW3 also agreed that the second defendant, who gave the instruction to transfer the patient to the general ward, should have given the ward nurses specific instruction regarding close observation of the patient.

[122] Professor Chan (DW3) further testified that upon arrival of the patient at the general ward, she must be observed closely at least 1/2 hourly. She also agreed that apart from observing and recording the patient's vital parameters, the general condition of the patient also need to be observed.

[123] DW3 further agreed with the plaintiff's counsel that when the first plaintiff complained to the nurses about the patient becoming drowsy, the nurses should have immediately informed the doctors and the doctors should

have immediately come and assess the patient's condition. In the present case, the nurses had failed to so.

[124] DW3 then agreed the reasons that the patient had collapsed was because the patient had been discharged prematurely, she was hypotensive, she was on morphine and she had not been observed closely. Therefore the patient's collapse is expected.

[125] Beside Professor Chan (DW3), Dr Patrick Tan, the third defendant, testified that after the said surgery, the patient should be in the ICU for at least 24 hours for close observation and management.

[126] The third defendant also agreed that the patient's vital parameters like the pulse rate, blood pressure, respiration rate, the CVP and the urine output should be normalised before any decision can be made to transfer the patient out from the ICU.

[127] The third defendant further agreed that disaster can happen when the patient with morphine infusion was put in a private room away from the nursing counter and without any monitoring.

[128] In addition, the third defendant further agreed that the second defendant must communicate with him before the decision to transfer the patient out from ICU was made. In this case, the third defendant was not consulted.

[129] The third defendant also testified that based on the patient's condition at the material time her collapse at 3pm on the 4 June 2008 was not a surprise.

[130] Having heard the evidence of the doctors' own expert, the testimony of the third defendant, the plaintiffs' expert witnesses and the unstable condition of the patient at the material time, it is my finding that the transfer of the patient out from the ICU on 4 June 2008 was premature and had caused the patient to collapse in the general ward.

[131] It is also my finding that there was no specific instruction given by the second defendant to the nurses when the patient was transferred to the general ward and no close observation and monitoring of the patient at the general ward either by the nurses or the doctors.

[132] As such, the second defendant was negligent and in breach of duty of care when he gave the instruction to transfer the patient out of the ICU prematurely and without consulting the anaesthetist. He was also negligent for failing to give specific instruction to the nurses even though the patient needed close observation and monitoring after the said surgery.

[133] On the part of the nurses, the failure to inform the doctors after having received the complaint that the patient becoming drowsy was a negligent act of the nurses, taking into account the unstable condition of the patient.

[134] Apart from this, the non-observation and monitoring of the patient at least 1/2 hourly whether by the nurses or the doctors is also another negligent conduct by the nurses and the doctors.

[135] It is also my findings that the negligence of the doctors after the surgery or post operation is within the plaintiff pleaded case. Among the particulars of negligence pleaded by plaintiffs are as follows:

(i) failed to have in place a proper and effective system for detecting and acting without delay on complications suffered by the third plaintiff following such procedure, alternatively failed to follow it;

(ii) failed to ensure that there was in place a proper and effective system for taking precautions against causing injury such as that suffered by the third plaintiff, alternatively failed to follow it; and

(iii) failed to have safe and a reliable system to provide sufficient and adequate treatment to treat the injuries caused by the operation.

Causation

[136] The plaintiffs have to prove causation on the balance of probabilities. In this case, it must be shown that the quadriplegia that the patient suffered was caused or materially contributed by the defendant's negligence. (See *Bonnington Castings Ltd v. Wardlaw* [1956] AC 613 and *McGhee v. National Coal Board* [1973] 1 WLR 1).

[137] In *Bennett v. Minister of Community Welfare* [1992] 176 CLR 408 the test to determine causation was explained further by taking the common sense approach as follows:

> In the realm of negligence causation is essentially a question of fact, to be resolved as a matter of common sense. In resolving that question, the but for test, applied as a negative criterion of causation has an important role to play but it is not a comprehensive and exclusive test of causation, value judgments and policy considerations necessarily intrude.

[138] In the present case, the evidence of the plaintiffs' expert, Dr Kuldip Singh (PW2) and corroborated by Dr Sylvian Dass has proved that the surgery performed by the doctors had caused the patient to suffer quadriplegia.

[139] PW2 also explained that the patient's act of moving her limbs after the surgery was not an assessment of neurological deficit. Quadriplegia could still happen due to the surgery as materialised in this case.

[140] On the part of the hospital, the failure to provide adequate facilities and safety protocols at the hospital had caused the patient to suffer the injuries, that is quadriplegia.

[141] In this case, the facts shows that there was a major problems at the hospital during the material time which can be termed as organisational and system failure. This is clearly admitted by the doctor who has practiced for

years in the hospital, Dr Patrick Tan. I see no reason to reject his testimony as his evidence is not something 'inherently incredible' and his main concern is the interest of patients at the hospital.

[142] Dr Patrick Tan, the third defendant, testified that the hospital medical administration had not set the required safety protocols or policies and giving example the policy to prevent patient from being discharged without consulting the anaesthetist. He also admitted that the nurses at the hospital were not well trained apart from the facilities which were inadequate. He then agreed that a failure to have appropriate safety protocols is an indication of failure on the part of the doctors and the hospital. He also agreed that the patient's care has suffered due to the problems between the doctors and the hospital management.

[143] To me, this organisational and system failure of the hospital in the present case give rise to direct liability on the part of the hospital as submitted by the plaintiffs, which I agree.

[144] It is also my findings that causation of injuries and negligence at the post operative stage have been pleaded by the plaintiffs against the hospital. This can be seen at paras. 11-2 to 11-18 of the counterclaim where the particulars of negligence by hospital were stated.

The Doctrine Of Non-Delegable Duty

[145] As to the issue of non-delegable duty of the hospital, the first defendant contended that there is no indication, that the appellate courts in Malaysia have accepted this doctrine which originated from United Kingdom. In any event, it was submitted that the doctrine is not applicable in the present case.

[146] The reason given by counsel for the first defendant is that the application of this doctrine in Malaysia involves public policy consideration as the acceptance of this doctrine will cause hospital insurance premium to increase. Consequently, Malaysian citizen has to pay higher medical bills.

[147] To my mind, the paramount considerations here is the healthcare of patients who attend a hospital for treatment. This doctrine underlines that a hospital owes a non-delegable duty of care to patients and to ensure that the healthcare provided either by his servant or agent under a contract of service or contract for service is not negligent.

[148] This doctrine of non delegable duty, to me is an extension of the concept of direct liability of a hospital. As stated in '*Medical Negligence* by A Jones, 2013 Edition':

> The concept of the direct liability of a hospital authority is used in two distinct ways. First, where the authority is itself at fault in the manner in which it has performed its functions, although it may not be possible to identify any particular employee who was negligent. This may be categorised as a form of organisational failure. Second, direct liability is

also used to describe the imposition of a non-delegable duty, for the purpose of establishing the authority's responsibility for the negligence of an independent contractor.

[149] Lord Denning has explained the doctrine of non-delegable duty in *Cassidy v. Ministry of Health* [1951] 2 KB 343 as follows:

> I take it to be clear law, as well as good sense, that, where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract for services ... the hospital authorities accepted the plaintiff as a patient for treatment, and it was their duty to treat him with reasonable care. They selected, employed, and paid all the surgeons and nurses who looked after him. He has no say in their selection at all. If those surgeons and nurses did not treat him with proper care and skill, then the hospital authorities must answer for it, for it means that they themselves did not perform their duty to him. I decline to enter into the question whether any of the surgeons were employed only under a contract for services, as distinct from contract of service. The evidence is meagre enough in all conscience in that point. But the liability of the hospital authorities should not and does not, depend on nice considerations of that sort. The plaintiff knew nothing of the terms on which they employed their staff, all he knew was, that he was treated in the hospital by people whom the hospital authorities appointed and the hospital authorities must be answerable for the way in which he was treated.

[150] On this issue, taking into account that the paramount important is the healthcare of patients and the rationale of this doctrine of non-delegable duty as explained in *Cassidy v. Minister of Health*, I do not see any reason not to apply this doctrine in our court. This doctrine will certainly put hospital authority on alert to ensure excellent healthcare to patients and provide all the required safety protocols to be followed strictly by their staffs or their independent contractors and this certainly will help to avoid or minimise their negligent act. In a way, this doctrine will help to improve the organisational and the system of a hospital.

Vicarious Liability

[151] The often-quoted case with regard to principle of vicarious liability is *Roe v. Minister of Health* [1954] 2 QB 66 where Lord Denning at p. 82 stated this:

> In the first place, I think that the hospital authorities, are responsible for the whole of their staff, not only for the nurses and doctors, but also for the anaesthetist and the surgeons. It does not matter whether they are permanent or temporary resident or visiting, whole time or part time. The hospital authorities are responsible for all them. The reason is because, even if they are not servants, they are the agents of the hospital to give the treatment. The only exception is the case of consultant or anaesthetist selected and employed by the patient himself.

[152] Counsel for the first defendant contended that the relationship between the hospital and the second and third defendants is purely a contractual relationship based on the contract for service entered into between CY Orthospine Sdn Bhd and M Anthony LKS Tan Sdn Bhd and the hospital. It was further submitted that the hospital is only a collecting agent for the doctor's fees paid by the patient and has no control over the doctors in their clinical judgment and the manner they conducted the surgery on the 3 June 2008.

[153] In this context, I have made my finding that the nurses of the hospital were negligent and in breach of duty of care to the patient. As the nurses are employees and staff of the first defendant, therefore the first defendant is vicariously liable for their negligent act.

[154] In *Cassidy v. Ministry of Health* (*supra*) Lord Denning at p. 586 had this to say:

> ... there can be no doubt now that the nurses remain the servants of the hospital authorities, even when they are under the direction of the surgeon in the operating theatre. The reason is because the nurses are employed by the hospital authorities, paid by them, and liable to be dismissed by them ...

[155] With regard to the position of the second, third and fourth defendants, although they are not employees of the hospital and work at the hospital on contract for service, the following clauses of the agreement as highlighted by counsel for the doctors are pertinent to note:

(i) clause 5.4 - the doctor is automatically become member of the Medical and Dental Staff of the Hospital and subject to the by laws of the Medical and Dental Staff.

(ii) clause 5.5 - the doctor only provide his services during office hours of working days of the Hospital.

(iii) clause 5.6 - the doctor to devote all his time, attention and abilities to the business of the Hospital.

(iv) clause 5.10 - the doctor to provide 24 hours coverage for all patients admitted to the Hospital under his care and service and the doctor must be one who his credential and approved by the hospital.

(v) clause 5.11 - the doctor must ensure the patients medical record must be completed within 5 working days from the date of discharge of the patients and failing which the Hospital have the right to withhold payment of the medical fees.

[156] As for the fourth defendant, he was involved in the surgery on the 4 June 2008 only upon the approval of the hospital and the hospital's executive committee agreed to give him a fee of RM5,000.

[157] Having analysed all these facts, it shows that the hospital had some control over the doctors in the performance of their duty in the hospital and looking in totality the doctors are in fact the agent of the hospital in providing

A the healthcare to the patient. Therefore, the hospital is vicariously liable for the negligent acts of the doctors.

[158] To sum up and in answering the issues to be tried in this case, my findings are as follows:

B (i) the second, third and fourth defendants were negligent and in breach of duty of care in treating the third plaintiff;

(ii) the second and fourth defendant were negligent and had not acted in accordance with the standard of care expected of an orthopaedic and spine surgeon;

C (iii) the third defendant was negligent and had not acted in accordance with the standard of care expected of an anaesthetist;

(iv) the first defendant was negligent and in breach of its contractual duty in the treatment and management of the patient;

D (v) the first defendant was vicariously liable for the negligence of the nurses, second, third and fourth defendants;

(vi) the quadriplegia suffered by the third plaintiff was caused or materially contributed by the negligence of the defendants; and

E (vii) the plaintiffs are entitled to damages, interest and cost.

[159] As there is no material or evidence before me to apportion the liability between the doctors and the hospital, no apportionment of liability is made in the present case.

F **Quantum Of Damages**

[160] As liability against the defendants has been proven, the next issue is with regard to the damages.

[161] The object or purpose of awarding general damages to the patient is to try as humanly possible to put the patient back to the position she would G have been before the surgery. The damages must be fair adequate and not excessive. (see *Yang Salbiah & Anor v. Jamil Harun* [1981] 1 LNS 106; [1981] 1 MLJ 292 and *Shanmugam Gopal v. Zinal Abidin Nazim & Anor* [2003] 8 CLJ 729; [2003] 3 MLJ 76).

H **[162]** As to the special damages, it must be specifically pleaded and strictly proved by the plaintiffs either by oral or documentary evidence. In *Ong Ah Long v. Dr S Underwood* [1983] 2 CLJ 198; [1983] CLJ (Rep) 300; [1983] 2 MU 324, Syed Agil Barakhbah FJ emphasised this principle and stated as follows:

I > It is well-established principle that special damages in contrast to general damages, have to be specifically pleaded and strictly proved. They are recoverable only where they can be included in the proper measures of damages and are not too remote (see *Halsbury's Laws of England*, 4th Edn, volume 11 p. 218, paragraph 386) That in our view is the cardinal principle adopted by all courts both in England and this country.

[163] On the quantum of damages in the present case, the plaintiffs are relying on the evidence of Dato' Balwant Singh Bains (PW5) a consultant physiotherapist and Dr Mohd lzmi (PW6) a rehabilitation physician.

[164] Both expert had visited the patient at the hospital and made observation and clinical evaluation. The findings are reflected in their experts reports as tendered in this court. In Dr Mohd Izmi (PW6) report dated 13 March 2015 stated among others as follows:

(i) the patient was a High Level (C4) Complete Tetraplegia;

(ii) she has been relying on continuous bladder drainage due to bladder incontinence;

(iii) she is unable to defecate and requires assisted bowel (digital) evacuation by the nurses;

(iv) she is fully assisted in feeding and drinks by using a straw;

(v) she need total assistance for bathing, dressing and grooming; and

(vi) she need total assistance for mobility in bed or indoors.

[165] PW6 then concludes that the patient is totally dependent on care givers and requires numerous equipment and facilities for optimising her quality of life and to prevent and manage the medical complications associated with her injury. PW6 also stated that the patient's neurological and functional status is permanent and no recovery is expected.

[166] The evaluation by Dato' Balwant Singh (PW5) as stated in his report dated 5 December 2014 is almost the same as PW6 with regard to the patient's condition.

[167] On the other hand, the defendants did not called any expert to testify with regard to the condition of the patient or as to the quantum of damages in the present case.

Special Damages And Pre Trial Damages

Medical Expenses

[168] Firstly, the plaintiffs claimed for a refund of RM20,000 which was paid to the hospital for the surgery. I am of the view that this claim is not justifiable having considered the fact that the surgery had been carried out on the patient and the fact that the hospital did not start billing the patient until three years after the surgery. As such this claim is disallowed.

[169] I also disallowed the plaintiffs' claim for the unpaid medical expenses by the patient to be awarded as special damages to the plaintiffs as the medical expenses is not expenses incurred out-of-pocket by the plaintiffs.

Travel Expanses

[170] The plaintiffs claimed for the travelling and miscellaneous expenses for the visits to the hospital from their house in Kg Veldor, Sg Bakap Penang. The amount of claim is RM800 per month for 84 months totalling RM67,200.

[171] I have analysed the evidence but could not find any oral or documentary evidence to support this claim. The patient's mother, Ang Mooi Sim (PW3) was called to testify but nothing was mentioned about the travelling and miscellaneous expenses incurred by the parents.

[172] Therefore, this claim is also disallowed.

Future Care And Expenses

[173] Before I proceed with this issue of future care and expenses, I am of the view that the patient is entitled to be discharged back home instead of remaining in the hospital as submitted by counsel for the doctors. To me that best quality life for the patient is for her to be with the family. With proper facilities and care at home, it is possible for the patient to be placed with her family.

Life Expectancy

[174] The cost of the patient future needs is depending on her life expectancy and in this case, two experts had given their opinion on the patient's life expectancy.

[175] Dato' Balwant Singh (PW5) opined that the patient's life expectancy to be 60 years and based his opinion on his 30 years of experience working with disabled persons including person who suffers tetraplagic.

[176] The other expert, Dr Mohd lzmi (PW6) is of the view that the patient's life expectancy is 44.9 years if the patient remains ventilator dependant. PW6 arrived at this figure by taking the patient's age at injury at 20 years plus additional 24.9 due to ventilator dependant.

[177] PW6 further opined that if the patient can be weaned off from the ventilator her life expectancy would be 56.6 years, that is 20 years the patient's age at injury plus 36.6 as the patient falls under the category of High Tetra (C1- C4).

[178] PW6's calculation is based on the data from the National SCI Statistical Centre (NSCISC) Database, Alabama, United States which was published in 2013.

[179] PW6's opinion was challenged by counsel for the first defendant that he had wrongly calculated the patient's age at injury at 20 years old although the patient's age at injury was actually 12 years old.

[180] Even though PW6 admitted that he make a mistake by using the patient's age at injury at 20 years and not 12 years, nevertheless PW6 explained that his calculation would not be much different. He said that the

age by 12 years and 20 years are under the category of young age which do not usually have medical morbidities, hypertension and diabetes compared to persons above 40 years old. Therefore, PW6 maintained that his opinion on the patient's life expectancy is correct.

[181] Counsel for the first defendant also referred to an article "*Trends in Life Expectancy After Spinal Cord Injury*" which mentioned that the average life expectancy of patients who suffered spinal cord injury is about 26.4 years from the time of injury. To this, PW6 explained that the said article which was published in 2006 is not the recent published article and PW6 had relied his calculation based on the most recent publication.

[182] In the present instance, the facts shows that no efforts had been made to wean the patient off the ventilator. However, as stated in PW6's report that in theory, a C4 tetraplegia can be weaned of ventilator because of the innervations of diaphragm and para-spinal muscles is intact.

[183] On this issue, which related to future event occurring, that is the patient being successfully weaned off the ventilator, I agree with the plaintiffs' counsel that the plaintiffs only need to show a possible likelihood that it would happen.

[184] In a Canada case, *Schrump Et v. Koot Et Al Lexsee* 18 OR (2D) 337 stated this:

> In assessing damages for personal injuries the award may cover not only all injuries actually suffered and disabilities proved as of the date of trial, but also the 'risk' or 'likelihood' of future developments attributable to such injuries. It is not the law that a plaintiff must prove on a balance of probabilities the probability of future damage; he may be compensated if he proves in accordance with the degree of proof required in civil matters that there is a possibility or a danger of some adverse future development.

[185] On this issue having considered the argument by parties and the experts opinion, I am of the view the life expectancy of the patient based on the NSCISC database and the correct calculation would be as follows:

(i) 12 (age of patient at injury) + 24.9 (ventilator dependent) = 36.9 years; and

(ii) 12 (age of patient at injury) + 36.6. (High Tetra (C1-04)) without ventilator = 48.6 years.

[186] Based on the evidence and having considered the experts opinion, I am of the view that there is possible likelihood that the patient be weaned off the ventilator. In absence of other expert opinion to the contrary, I find that the life expectancy of the patient at 48.6 years is reasonable.

The Multiplier

[187] Consequently, the calculation of the multiplier is as follows:

48.6 (life expectancy) - 18 (the Patient current age) - 30% (for contingencies and vicissitudes of life) = 21.4 years

[188] In the present case, the future general damages sought by the plaintiffs are as follows:

(i) cost of a disable friendly home;

(ii) cost of a disabled - friendly mode of transportation;

(iii) cost of carers; and

(v) cost of personal and hygiene supplies and facilities.

Disabled Friendly Home

[189] Counsel for the first defendant submitted that no evidence had been adduced to support the claim for the plaintiff's home renovation. However, if the court is minded to award cost of plaintiff's home renovation the amount of RM60,000 was said to be fair and reasonable.

[190] Dato' Dr Balwant Singh Bains (PW5) who had visited the plaintiff's house had given an estimate of RM200,000 for the costs of the home renovation. PW5 also testified that the estimation he made is based on his past experience and the estimation is only the bare minimal cost as it can go up to RM500,000.

[191] Dr Mohd lzmi (PW6) who had also visited the plaintiff's house recommended modification or renovation to the entrance, doorway, hallways, bedroom and bathroom of the house.

[192] Having considered both the expert evidence and the extensive renovation to be carried out at the plaintiffs' house, I am of the view that the amount of RM200,000 for the cost of renovation is reasonable. Therefore, I allowed the sum of RM200,000 as claimed.

Cost Of Disabled - Friendly Motor Vehicle

[193] It was contended by counsel for the first defendant that no evidence was adduced that the patient could not fit into a sedan car or could only fit into an MPV or ambulance.

[194] Here, Dato' Dr Bains (PW5) in his report stated that the cost of vehicle modified to lift motorised wheelchair is at the range between RM120,000 to RM160,000. PW5 was not cross-examined on this.

[195] Dr Mohd lzmi (PW6) also in his report stated that the patient need a modified van with lift facility for easy access of motorised wheelchair and wheelchair anchoring system.

[196] From the evidence, and taking into account the patient's condition, I agree to allow the claim for this modified vehicle. The claim for RM160,000 with three renewals is reasonable.

[197] Therefore, the cost of modified vehicle with three renewals for the total amount RM480,000 is allowed.

Costs Of Machines, Appliances And Equipment

[198] Counsel for the first defendant submits that the amount claimed by the plaintiffs is excessive without basis and justification.

[199] Conversely, counsel for the plaintiffs contended the need for all the machines, appliances and equipment has been justified by both their expert PW5 and PW6. The plaintiffs set out the details of the machines, appliances and equipment after avoiding any duplication of recommendation as shown in Table 1 as follows:

Table 1

Category	Items	Estimated Cost (RM)	Product Life Span (years)	Number of Renewals	Total
Respiratory equipment	Ventilator (Bipap)	26,000.00	10	3	78,000.00
	Suction equipment	700.00	5	6	4,200.00.
	Tracheotomy tube	125.00	Every 2 weeks	648	81,000.00
	Nebulizer	380.00	5	6	2,280.00
	Cough assist mechanical insufflator/ exsufflator	22,000.00	10	3	66,000.00
	Oxygen generator	5,500.00	3	9	49,500.00
	Philegm management device & vibrator	10000.00	3	9	90,000.00
	Triflo spironmeter for breathing exercise	200.00	2	14	2,800.00
Bed mobility & positioning	Fully electric hospital bed	20,00.00	5	6	120,00.00
	Cardiac table	380.00	10	3	1,140.00
	Pressure-relieving mattress	3,200.00	5	6	19,200.00
	S400 overlay	1,100.00	5	6	6,600.00
	Repair and maintenance	500.00	5	6	3,000.00

	Various shaped bolsters and wedges	3,000.00	3	9	27,000.00
	Bioptron light for bed sore management	11,000.00	3	9	99,000.00
	Multi stem exercise bed	40,000.00	3	9	360,000.00
Transfer equipment	Lifting electric hoist	10,000.00	10	3	30,000.00
Mobility devices & cushion	Powered recline and/or fit wheelchair with seating system	96,000.00	Unavailable (should be 10)	3	288,000.00
	Pressure -relieving wheelchair cushion	2,000.00	5	6	18,000.00
Devices for personal hygiene	Foley (silicon) catheter	50.00	Once a month	324	16,200.00
	Urine drainage bag	4.00	Once a month	324	1,296.00
	Padded reclining commode wheelchair with head support	1,500.00	5	6	9,000.00
	Shower trolley	15,000.00	8	4	60,000.00
	Hoist with railing and fixed to bathroom	12,000.00	-	-	12,000.00
	Lifting garment for hoist	700.00	2	14	9,800.00
	Maintenance cost	500.00	1	27	13,500.00
Devices to prevent contractures	Bilateral solid ankle foot orthnosis	800.00	2	14	11,200.00
	Bilateral resting hand orthnosis	580.00	2	14	8,120.00
	Contracture prevention for hand, foot and knee	3,000.00	3	39	27,000.00

Devices to aid communication - Electronic aids for daily activities ('E-ADLs')	Voice-activated devices or infra-red head control devices for computer and environmental control	26,000.00	10	3	78,000.00
Physiotherapy devices	Multi stem device and management at home	45,000.00	3	9	405,000.00
	G5 message therapy equipment	5,000.00	3	9	45,000.00
Home Modification	Air-conditioner	2,000.00	5	6	12,000.00
TOTAL					2,053,836.00

[200] Having considered the expert recommendations and justification which I am satisfied can withhold logical analysis, I am of the view that all the items recommended shown in Table 1 is acceptable. More over, there is no other expert evidence before this court to contradict PW5 and PW6 views on this matter.

[201] In any event, as the multiplier which has been decided is 21.4 years, the numbers of renewals for the items will be different.

[202] In any event, as the multiplier which has been decided is 21.4 years, the numbers of renewals for the items will be different and this will change the total amount of cost under this head. The details of its cost are reflected at Table 2 as follows:

Table 2

Category	Items	Estimated Cost (RNI)	Product Life Span (years)	Number of Renewals	Total
Respiratory equipment	Ventilator (Bipap)	26,000.00	10	2	52,000.000
	Suction equipment	700.00	5	4	2,800.00.
	Tracheotomy tube	125.00	Every 2 weeks	504	63,000.00
	Nebulizer	380.00	5	4	1,520.000
	Cough assist mechanical insufflator/ exsuffla tor	22,000.0	10	2	44,000.00

	Oxygen generator	5,500.00	3	7	38,500.00
	Philegm management device & vibrator	10,000.00	3	7	70,000.00
	Triflo spironmeter for breathing exercise	200.00	2	10	2,000.00
Bed mobility & positioning	Fully electric hospital bed	20,00.00	5	4	80,000.00
	Cardiac table	380.00	10	2	760.00
	Pressure-relieving mattress	3,200.00	5	4	12,800.00
	S400 overlay	1,100.00	5	4	4,400.00
	Repair and maintenance	500.00	5	4	2,000.00
	Various shaped bolsters and wedges	3,000.00	3	7	21,000.00
	Bioptron light for bed sore management	11,000.00	3	7	77,000.00
	Multi stem exercise bed	40,000.00	3	7	280,000.00
Transfer equipment	Lifting electric hoist	10,000.00	10	2	20,000.00
Mobility devices & cushion	Powered recline and/or fit wheelchair with seating system	96,000.00	Unavailable (should be 10)	2	192,000.00
	Pressure - relieving wheelchair cushion	2,000.00	5	4	8,000.00
Devices for personal hygiene	Foley (silicon) catheter	50.00	Once a month	252	12,600.00
	Urine drainage bag	4.00	Once a month	252	1,008.00
	Padded reclining commode wheelchair with head support	1,500.00	5	4	6,000.00

	Shower trolley	15,000.00	8	3	45,000.000
	Hoist with railing and fixed to bathroom	12,000.00	-	-	12,000.00
	Lifting garment for hoist	700.00	2	10	7,000.00
	Maintenance cost	500.00	1	21	10,500.00
Devices to prevent contractures	Bilateral solid ankle foot orthnosis	800.00	2	10	8,000.00
	Bilateral resting hand orthosis	580.00	2	10	5,800.00
	Contracture prevention for hand, foot and knee	3,000.00	3	7	21,000.00
Devices to aid communication - Electronic aids for daily activities ('E-ADLs')	Voice-activated devices or infra-red head control devices for computer and environmental control	26,000.00	10	2	52,000.00
Physiotherapy devices	Multi stem device and management at home	45,000.00	3	7	315,000.00
	G5 message therapy equipment	5,000.00	3	7	35,000.00
Home Modification	Air-conditioner	2,000.00	5	64	8,000.00
TOTAL					1,496,690.00

[203] Therefore, the total amount for cost of machines, appliances and equipment is RM1,496,690 which I allowed.

Cost Of Care

(i) Physiotherapy And Massage Therapy

[204] Both Dato' Bains (PW5) and Dr Mohd lzmi (PW6) mentioned that the patient needs physiotherapy. PW5 advised three visits a week for the rest of the patient's life at the rate of RM180 to RM200 per visit. I am of the view

that RM180 per visit and twice a week is reasonable and as such allowed the claim as follows:

RM180 per visit x 2 visits week x 52 weeks x 21.4 years = RM400,608

[205] PW5 also advised for massage therapy once a week for the rest of the patient's life at the rate of RM180 per week which is reasonable and acceptable. Therefore the claim allowed under this head is:

RM180 (per week) x 52 weeks x 21.4 years = RM200,304.

(ii) Cost Of Home Nursing

[206] Dato' Bains (PW5) stated that the patient need a trained maid and a nurse to take care of her at home. Likewise Dr Mohd Izmi (PW6) who mentioned in his report that the patient requires total nursing care at home that encompasses:

(i) all aspect of her personal activities;

(ii) all aspect of her domestic activities;

(iii) wound dressing for the existing pressure ulcers and skin management;

(iv) respiratory management; and

(v) range of movement activities.

[207] Having considered the argument by parties and considering the fact that home nursing involves high cost, I am of the view that RM10,000 per month is fair and reasonable. Therefore the total cost that I allowed for the cost of home nursing is:

RM10,000 x 12 months x 21.4 years = RM2,568,000.

Cost Of Future Medical Treatment /Consultations

[208] Dr Mohd lzmi (PW6) stated in his testimony that plaintiff may need hospitalisation and the duration of the hospitalisation will depend on her illness. PW6 also said that if it involve minor issue she may be hospitalised for one or two weeks but if it involves complicated problem, it may extend beyond two weeks or months.

[209] As the future treatment is something which is not predictable to happen consistently, I am of the view that the reasonable award would be RM10,000 per year and the total amount for cost of future treatment which I allowed is:

RM10,000 x 21.4 years = RM214,000.

(iii) Cost Of Personal And Hygiene Needs

[210] I allowed the sum of RM250 per month for this claim and the total sum is:

RM250 x 12 x 21.4 years = RM64,200.

General Damages For Pain And Suffering And Loss Of Amenities Of Life

[211] As stated earlier that the patient in this case is quadriplegic with the disabilities as stated in PW5 and PW6 expert's report.

[212] The decided cases on the quantum for such injury are as follows:

(i) *Gleneagles Hospital (KL) Sdn Bhd v. Chung Chu Yin & Ors and Another Appeal* [2013] 8 CLJ 449 ... RM350,000;

(ii) *Nurul Husna Muhamad Hafiz & Anor v. Kerajaan Malaysia & Ors* [2015] 1 CLJ 825 ... RM350,000;

(iii) *Eddy anak Entering v. Azimudin bin Majidin & Anor* [2014] 1 PIR [16] ... RM400,000; and

(iv) *Ku Jia Shiuen & Anor v. Kerajaan Malaysia & Ors* [2013] 9 CLJ 489; [2013] 3 MLJ 108 ... RM350,000.

[213] Having considered the authorities cited above and the condition of the patient, the award of RM400,000 for pain and suffering and loss of amenities is fair and reasonable in the present case.

[214] Therefore, the total award for damages to the plaintiffs are as follows:

(i)	General Damages - future care:		
	(a) Cost of Disabled Friendly Home	-	RM200,000
	(b) Cost of Disabled Friendly - motor vehicle	-	RM480,000
	(c) Cost of machines, appliances and equipment	-	RM1,496,690
	(d) Cost of physiotherapy	-	RM400,608
	(e) Cost of massage therapy	-	RM200,304
	(f) Cost of home nursing	-	RM2,568,000
	(g) Cost of future treatment	-	RM214,000
	(h) Cost of personal and hygiene needs	-	RM64,200
			RM5,623,802
(ii)	General Damages for Pain and Suffering and loss of amenities of life	-	**RM400,000**
	Total		**RM6,023,802**

Conclusion

[215] The plaintiff's claim in the original action for the outstanding medical bills is allowed.

[216] The defendants in the original action is to pay the plaintiff the amount of RM2,350,013.85.

[217] I also order the defendants in the original action to pay cost to the plaintiff in the sum of RM20,000.

[218] The interest shall be at the rate of 5% per annum on the judgment sum until full realisation.

[219] In the counterclaim the defendants who become the plaintiffs, claim for damages for medical negligence. The plaintiffs claim is allowed.

[220] The defendants in the counterclaim is to pay the plaintiffs general damages of RM6,023,802.

[221] The interest for the general damages of RM6,023,802 shall be at the rate of 8% per annum from date of filing the suit until date of judgment.

[222] There shall also be an interest at the rate of 5% per annum on the judgment sum until full realisation.

[223] I also order the defendants in this counterclaim to pay cost to the plaintiff in the sum of RM60,000.